

6796

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural - P. O. Gormaniam, W. Va.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION D O A, at Garrett Co. Mem. Hosp.		d. STREET ADDRESS Red Oak community	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Joseph Larry Brandt		4. DATE OF DEATH Month Day Year June 12, 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 4, 1904
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder & Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James J. Brandt		14. MOTHER'S MAIDEN NAME Nancy Ellen Green	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 234-62-2593	
17. INFORMANT Address Mrs. Joseph Brandt-R.D. Gormaniam, W. Va.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Tracheal Obstruction DUE TO (c) Branchogenic Carcinoma, with generalized metastases			INTERVAL BETWEEN ONSET AND DEATH 0 1-2 minutes 12-18 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from February, 1959 , to June, 1959 , that I last saw the deceased alive on May 15, 1959 , and that death occurred at 7:05 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Richard F. Leighton M.D.		ADDRESS (Street, city or town, state) 5th & Oak Sts., Oakland, Md. DATE SIGNED 6/12/1959	
PHYSICIAN'S NAME (Type) Richard F. Leighton, M. D.		Oakland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/14/1959	22c. NAME OF CEMETERY OR CREMATORY Gregory Family Cemetery	22d. LOCATION (City, town, or county) (State) Red Oak, Garrett Co., Md.
23. FUNERAL DIRECTOR'S SIGNATURE R. F. Leighton		ADDRESS Oakland, Md.	24a. REC'D BY REGISTRAR JUN 16 '59
		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies.

CERTIFICATE OF DEATH

MASSACHUSETTS
STATE DEPARTMENT OF HEALTH
BOSTON, MASS.

Form with multiple horizontal lines for text entry, including fields for name, age, sex, date of death, and cause of death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06787

6797

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA MINERAL b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN 1b 7 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HERBERT Middle T. Last DAWSON		4. DATE OF DEATH Month JUNE Day 19 Year 1959	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/11/1887
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAIL CARRIER		10b. KIND OF BUSINESS OR INDUSTRY Rural Contract	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM THOMAS DAWSON		14. MOTHER'S MAIDEN NAME ELIZABETH BAILEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 236-12-2574	
17. INFORMANT LILLIE DAWSON		Address SHAW, WEST VIRGINIA	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 7 days years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-12 , 19 59 , to 6-19 , 19 59 , that I last saw the deceased alive on 6-19-59 , 19 59 , and that death occurred at 12:15 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE James H. Feaster, Jr.		ADDRESS (Street, city or town, state) 582nd St. Oakland Md	
PHYSICIAN'S NAME (Type) JAMES H. FEASTER, JR., M.D.		DATE SIGNED 6.20.59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/22/1959	
22c. NAME OF CEMETERY OR CREMATORY Ebenezer Church Cemetery, Romney, W. Va.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE H. C. Leighton		ADDRESS Oakland, Md.	
24a. REC'D BY REGISTRAR DATE JUN 23 '59		24b. REGISTRAR'S SIGNATURE Arthur S. House	

4 15 24

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

CERTIFICATE OF DEATH

WILLIAM BOND

DATE

PLACE

CAUSE

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

RACE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6798 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06788

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gorman		c. LENGTH OF STAY IN 1b 80 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gorman			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 7		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DANIEL Middle ANDREW Last EGER				4. DATE OF DEATH Month JUNE Day 27 Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH unk/unk/1870		9. AGE (In years last birthday) 89 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Daniel Eger				14. MOTHER'S MAIDEN NAME Barbara Yockum			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none		17. INFORMANT Address Mrs. Ruth Miller Tacoma Park, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION, ACUTE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i> EXAMINER'S NAME (Type) JAMES H. FEASTER, JR., M. D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 6/30/1959		22c. NAME OF CEMETERY OR CREMATORY Pope Cemetery	
23. FUNERAL DIRECTOR'S SIGNATURE Gerald N. Minnich Oakland, Maryland				24a. REC'D BY REGISTRAR DATE JUL 6 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur L. House</i>	
22d. LOCATION (City, town, or county) (State) Gorman Maryland				DATE SIGNED 6-28-59			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

100-500

WESTLAND STATE DEPARTMENT OF HEALTH - DIVISION OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Date of Death		Time of Death		Place of Death	
Cause of Death		Manner of Death		Occupation	
Medical History		Physical Examination		Mental Examination	
Autopsy		Toxicology		Microbiology	
Pathology		Radiology		Other	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
Date of Signature		Date of Signature		Date of Signature	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6799

CERTIFICATE OF DEATH

06789

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland,</u>		c. LENGTH OF STAY IN lb <u>27 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>D O A Oakland Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ray</u> Middle <u>Leibowitz</u> Last <u>Feld</u>		4. DATE OF DEATH Month <u>June</u> Day <u>30</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 29, 1890</u>
9. AGE (In years last birthday) yrs. <u>69</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Leibowitz</u>		14. MOTHER'S MAIDEN NAME <u>Lena Glass</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Irvin Feld</u>		Address <u>Oakland, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Insufficiency</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardio Vascular Disease</u> DUE TO <u>20 years</u> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>11:50 P</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March</u> 19 <u>57</u> to <u>June</u> 19 <u>59</u> , that I last saw the deceased alive on <u>June 5</u> 19 <u>59</u> , and that death occurred at <u>11:50 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>770 Oak Street, Oakland, Md.</u> DATE SIGNED <u>July 1, 1959</u> ACTUAL SIGNATURE <u>Herbert H. Leighton</u> M.D. PHYSICIAN'S NAME (Type) <u>Herbert H. Leighton, M. D.</u> <u>Oakland, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/3/1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mogen Abraham Cemetery, Rosedale, Baltimore, Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. C. Leighton</u> ADDRESS <u>Oakland, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 6 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10-12-19

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

10-12-19

10-12-19



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6800

CERTIFICATE OF DEATH

06790

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garre tt MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland Rt# 2		c. LENGTH OF STAY IN 1b unk	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Oakland Rt# 2	
		d. STREET ADDRESS /	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Emma Christine Frazee		4. DATE OF DEATH Month 6 Day 29 Year 19 59	
5. SEX Femal	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/25/1893
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) domestic		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Accident, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Margroff		14. MOTHER'S MAIDEN NAME Hanna Fredick	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mr. Carl Frazee		Address Oakland Rt# 2, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 451X Aneurysm Ruptured DUE TO (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH Sudden	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-3-1958 to 6-29-1959, that I last saw the deceased alive on 6/26/1959, and that death occurred at 9:45 PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Andrew E. Mance M.D.		ADDRESS (Street, city or town, state) DATE SIGNED Oakland Md 30/July/59	
PHYSICIAN'S NAME (Type) A.E.MANCE, M.D.		OAKLAND, MARYLAND 30/July/1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 7/2/1959	
22c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery		22d. LOCATION (City, town, or county) (State) Oakland Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Gerald N. Minnich		ADDRESS Oakland, Maryland	
24a. REC'D BY REGISTRAR DATE JUL 6 '59		24b. REGISTRAR'S SIGNATURE C. L. S. Kiana	

MEDICAL CERTIFICATION

WILLIAM BORD

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

1911

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

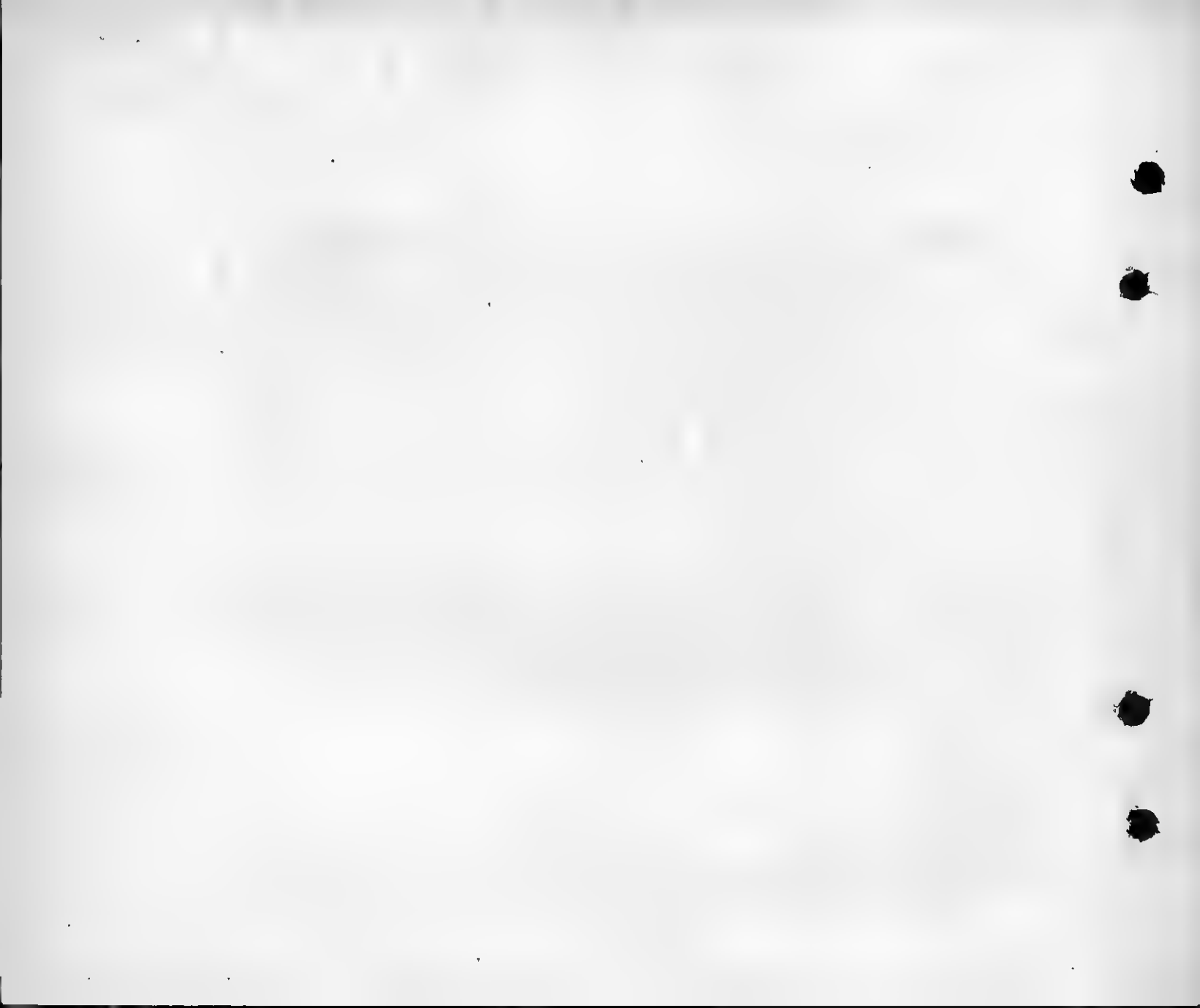
6801

CERTIFICATE OF DEATH

06791

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Garnett</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garnett</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wetmore, Md.</u>		c. LENGTH OF STAY IN 1b <u>15 Months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>ILCTZ</u> Last <u>ILCTZ</u>		4. DATE OF DEATH Month <u>June</u> Day <u>9</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 11, 1872</u>
9. AGE (In years last birthday) <u>87</u> yrs		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	11. IF UNDER 24 HRS Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own farm</u>	
11. BIRTHPLACE (State or foreign country) <u>William, Garrett Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Christian Klotz</u>		14. MOTHER'S MAIDEN NAME <u>Mary Pope</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. <u>216-38-1942</u>	
17. INFORMANT <u>Raymond Klotz, McHenry, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u>Arteriosclerosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>10 years</u> <u>10 years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>58</u> , to <u>June 9</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 8</u> , 19 <u>59</u> , and that death occurred at <u>5:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C.W. Stotler M.D.</u>		ADDRESS (Street, city or town, state) <u>349 Main St. Meyerdale, Pa.</u> DATE SIGNED <u>6/10/59</u>	
PHYSICIAN'S NAME (Type) <u>C.W. STOTLER M.D.</u>		<u>349 MAIN ST. MEYERDALE PA.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/12/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Accident</u>	22d. LOCATION (City, town, or county) (State) <u>Accident Garrett Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Josef Newman</u>		ADDRESS <u>Grantville, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE JUN 16 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	



INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and complially filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

6802

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06792

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY GARRETT		STATE MARYLAND		COUNTY GARRETT			
CITY (If outside corporate limits, write RURAL and give nearest town) KITZMILLER		LENGTH OF STAY 43 yrs.		CITY (If outside corporate limits, write RURAL and give nearest town) KITZMILLER			
HOSPITAL OR INSTITUTION OR STREET ADDRESS MAIN STREET				STREET ADDRESS (If rural give location) MAIN STREET			
3. NAME OF DECEASED (Type or Print) MAUDE (First) ELIZABETH (Middle) KNOTTS (Last)				4. DATE OF DEATH (Month) JUNE (Day) 17 (Year) 59			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH APRIL 8, 1882	9. AGE last birthday 77 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H. C. WORK		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES EVERETT				14. MOTHER'S MAIDEN NAME ALICE DULEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unk.) NO		16. SOCIAL SECURITY NO. 216-09-2792B		17. INFORMANT & ADDRESS Elza Knotts, Kitzmiller, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) Acute Myocardial Infarction						3 days	
ANTECEDENT CAUSE(S) DUE TO (B) Cerebral Thrombosis with rt sided paralysis						5 yrs	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Fracture of rt hip						8 yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Feb 7, 1951, to June 17, 1959, that I last saw the deceased alive on June 17, 1959, and that death occurred at 9:50 P.M. from the causes and on the date stated above.							
SIGNATURE <i>Ralph Calandulla</i>				ADDRESS (Street, city, town, state) <i>Kitzmillers Md</i>		DATE SIGNED <i>June 18-59</i>	
23. BURIAL, CREATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 6/20/59		NAME OF CEMETERY OR CREMATORY I.O.O.F. Cemetery		LOCATION (City, town, or county) (State) Elk Garden, W.Va.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Arthur S. House</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>H.C. Longfellow</i>		ADDRESS Oakland, Md.	
DATE JUN 22 '59							

رغم ان هذا هو الحال في
(في حالة) الفهم - دكتور ف
على ان هذا هو الحال في
الحالة في حالة الفهم

في حالة الفهم في حالة الفهم
في حالة الفهم في حالة الفهم

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6803

CERTIFICATE OF DEATH

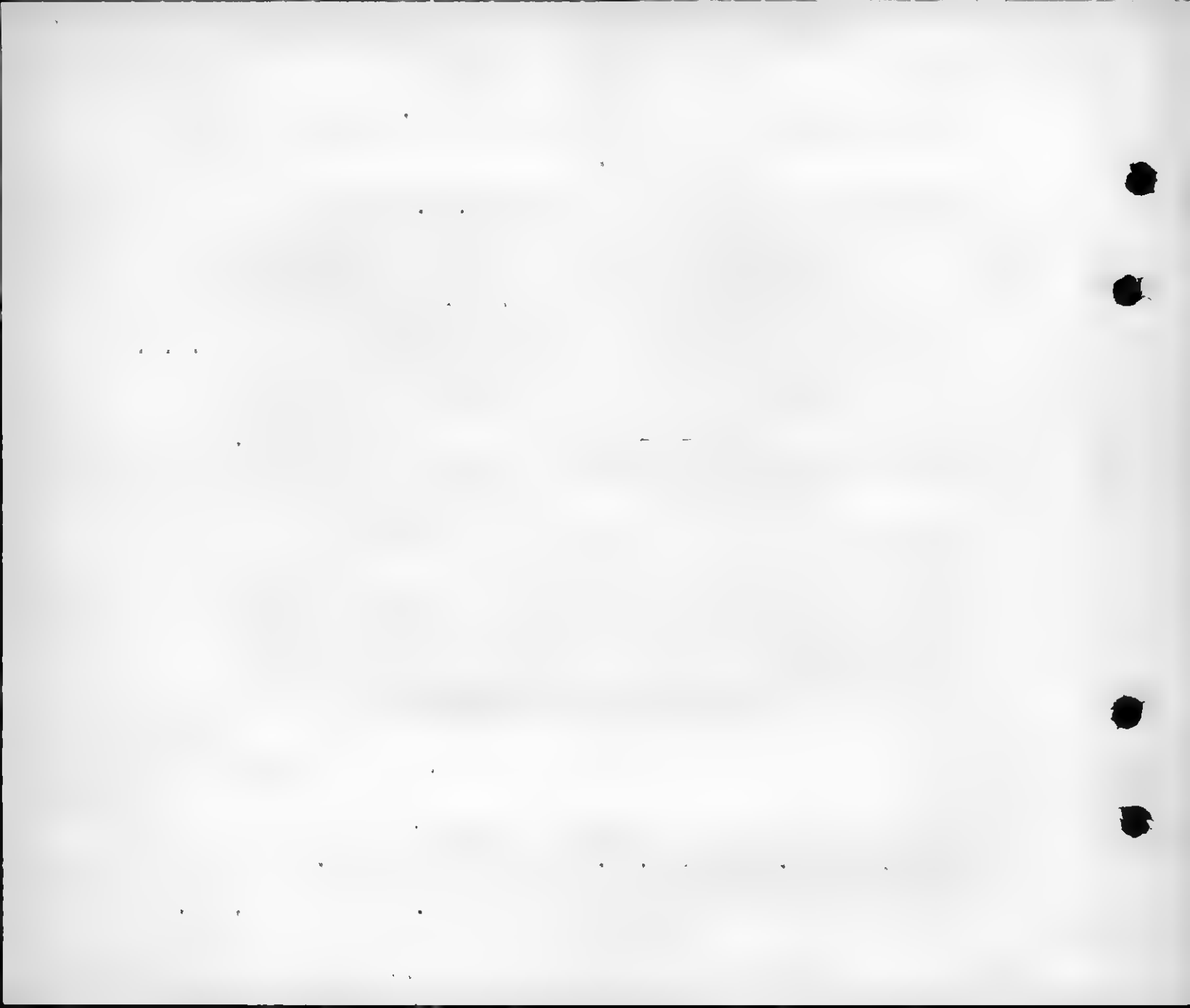
Reg. Dist. No.

06793

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland. b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Oakland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Oakland	
c. LENGTH OF STAY IN 1b 38 yrs.		d. STREET ADDRESS 19 Mi. S. Oakland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION near Red House		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Floyd Middle Lee Last Lee		4. DATE OF DEATH Month June Day 29 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 30, 1875
9. AGE (In years last birthday) 83 yn.		IF UNDER 1 YEAR Months 8 Days 29 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Perry Lee		14. MOTHER'S MAIDEN NAME Sarah Moreland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO 212-38-6196	
17. INFORMANT Earl Lee Address Oakland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 151X Carcinomatosis - metastatic DUE TO (b) Carcinoma of stomach DUE TO (c) Intestinal Sclerosis		INTERVAL BETWEEN ONSET AND DEATH 8 weeks 8 months 6 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-28-1958 to 6-29-1959 , that I last saw the deceased alive on 6-11-1959 , and that death occurred at M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Andrew E. Mance M.D.		ADDRESS (Street, city or town, state) Oakland Md DATE SIGNED 30 June 59	
PHYSICIAN'S NAME (Type) Andrew E. Mance, M. D.		Oakland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/2/1959	
22c. NAME OF CEMETERY OR CREMATORY Red House Church Cem.		22d. LOCATION (City, town, or county) (State) Garrett C., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. R. Righton ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR DATE JUL 6 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After it is determined that the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

6804 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

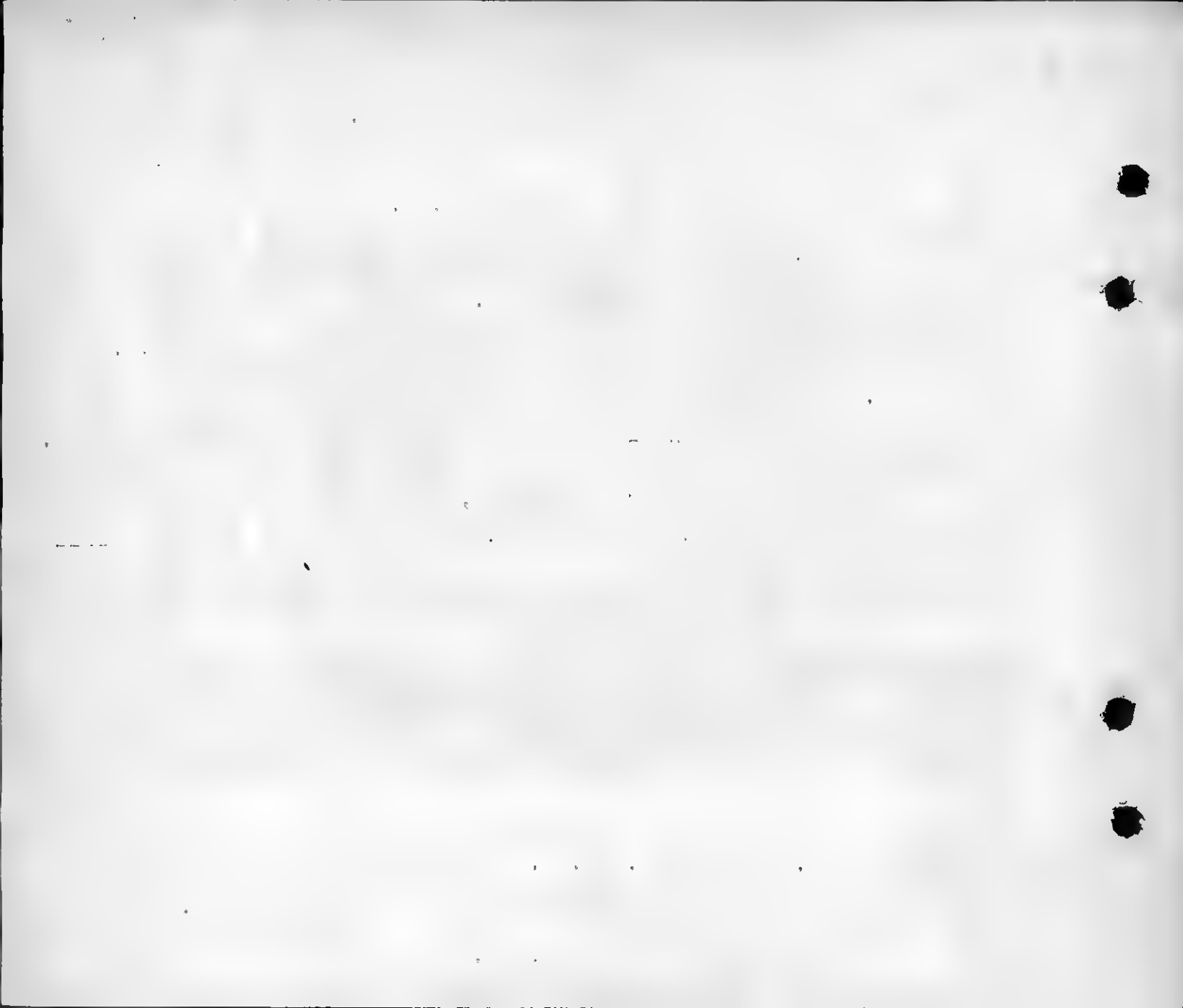
06794

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Garrett County Memorial Hospital</u>		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland.</u> b. COUNTY <u>Garrett</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Star Route, Oakland,</u> d. STREET ADDRESS <u>6 I.I. N. Oakland</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Michael</u> Last <u>Long</u>		4. DATE OF DEATH Month <u>June</u> Day <u>18,</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 12, 1883</u>	9. AGE (In years last birthday) <u>75</u> yrs.	10. IF UNDER 1 YEAR Months <u></u> Days <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Adam H. Long</u>		14. MOTHER'S MAIDEN NAME <u>Anna Catherine Bloss</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>218-12-5966</u>		17. INFORMANT <u>Lonnie Long</u> Address <u>Star Route, Oakland, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion, right</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary osteal sclerosis</u> DUE TO (c) <u></u>					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u></u> a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) <u></u>		20g. (County) <u></u>		20h. (State) <u></u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>James H. Feaster Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>6.19.59</u>	
EXAMINER'S NAME (Type) <u>James H. Feaster Jr., M. D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/21/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Deer Park Cemetery</u>	
				22d. LOCATION (City, town, or county) <u>Deer Park, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. R. Leighton</u>		ADDRESS <u>Oakland, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 22 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huang</u>	

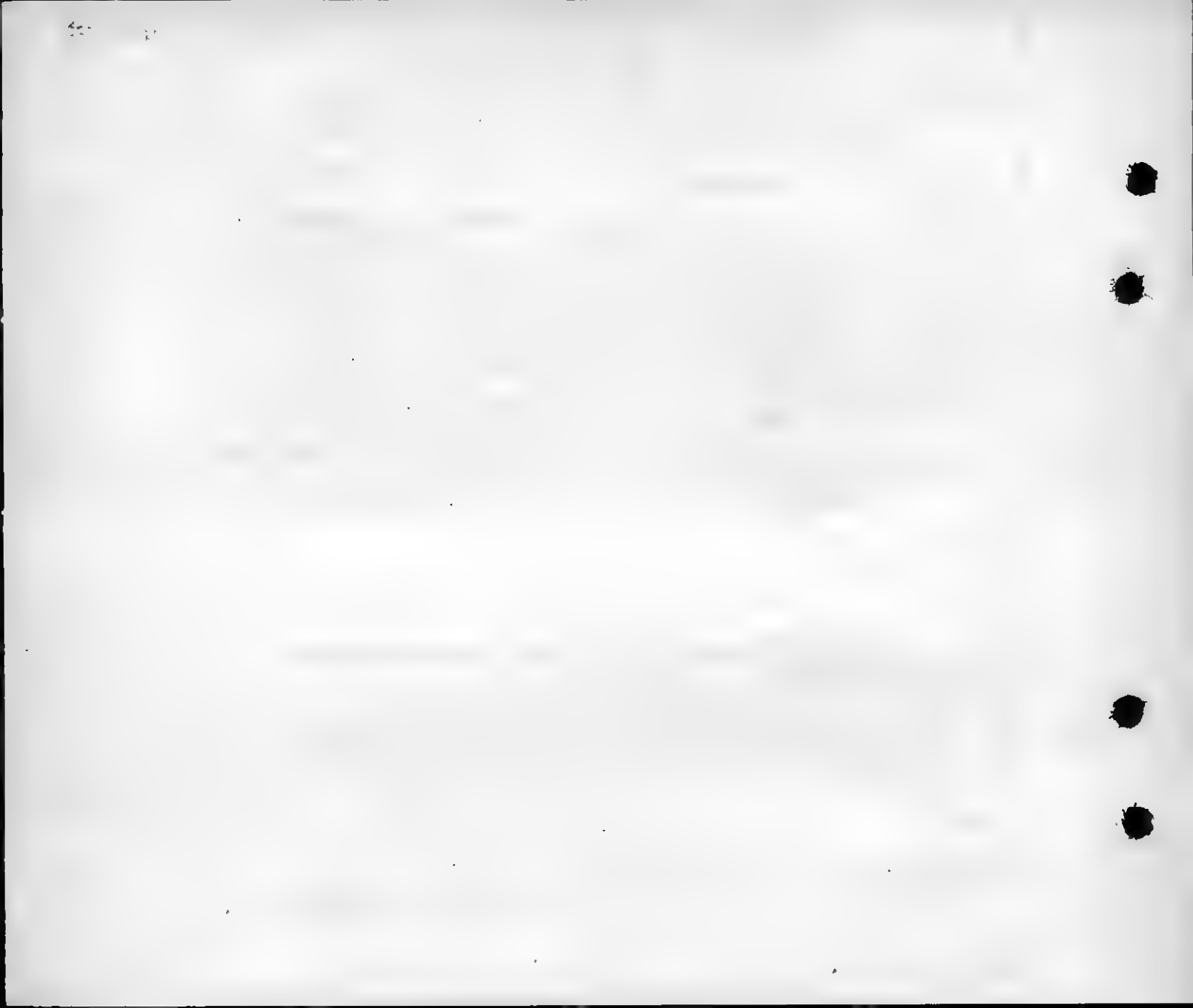
MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral home or, Page 4 should be forwarded to the State Board of Health. TO FUNERAL DIRECTOR: Page 3 could be used as a burial-transit permit. Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MEDICAL CERTIFICATION

VS A15 (4)
15M 10/57



Item 2 811-0244 7-20-59 at

06796

6806

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>GARRETT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Garrett</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Swanton</u>		c. LENGTH OF STAY IN 1b <u>1 week</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Swanton</u>		d. STREET ADDRESS <u>1 RFD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>GARRETT GOLDEN MEMORIAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>LILLIE</u> First <u>and</u> Middle <u>and</u> Last <u>WILSON</u>				4. DATE OF DEATH <u>5-25</u> Month <u>27</u> Day <u>1959</u> Year			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>July 6, 1878</u>	9. AGE (In years last birthday) <u>80</u> yrs	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	IF UNDER 24 HRS Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>ROBERT FLETCHER WILSON</u>				14. MOTHER'S MAIDEN NAME <u>OLGA WILSON WELCH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>---</u>		17. INFORMANT <u>Dr. C. C. ...</u> Address <u>...</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>carcinomatosis</u> <u>199.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerosis</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>6-7 years</u> <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JUNE 22,</u> <u>1959</u> , to <u>JUNE 27,</u> <u>1959</u> , that I last saw the deceased olive on <u>JUNE 26,</u> <u>1959</u> , and that death occurred at <u>4:45</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Andrew E. Mance</u> M.D.				ADDRESS (Street, city or town, state) <u>Oakland Md</u>		DATE SIGNED <u>27 June 59</u>	
PHYSICIAN'S NAME (Type) <u>DR. ANDREW E. MANCE</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/29/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>North Glade Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>near Swanton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. L. Lighton</u> ADDRESS <u>Oakland, Md.</u>				24a. REC'D BY REGISTRAR <u>JUL 1 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. ...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6807

CERTIFICATE OF DEATH

06797

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Deer Park,</u> c. LENGTH OF STAY IN 1b <u>60 yrs.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4 Mi. No. Deer Park, Md.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>xRural Deer Park,</u> d. STREET ADDRESS <u>4 Mi. North</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Andrew</u> Middle <u>Thomas</u> Last <u>Miller</u>		4. DATE OF DEATH Month <u>June</u> Day <u>13</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 24, 1890</u>
9. AGE (In years last birthday) <u>68</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wood Working</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Charles Miller</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Ann Johnson</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO <u>218-12-5125</u>		17. INFORMANT <u>Mrs. Hazel Glass</u> Address <u>R.D. Deer Park, Md.</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO <u>5-7-11</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Emphysema - Chronic</u> DUE TO <u> </u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> <u>10 years</u>
--	--	---

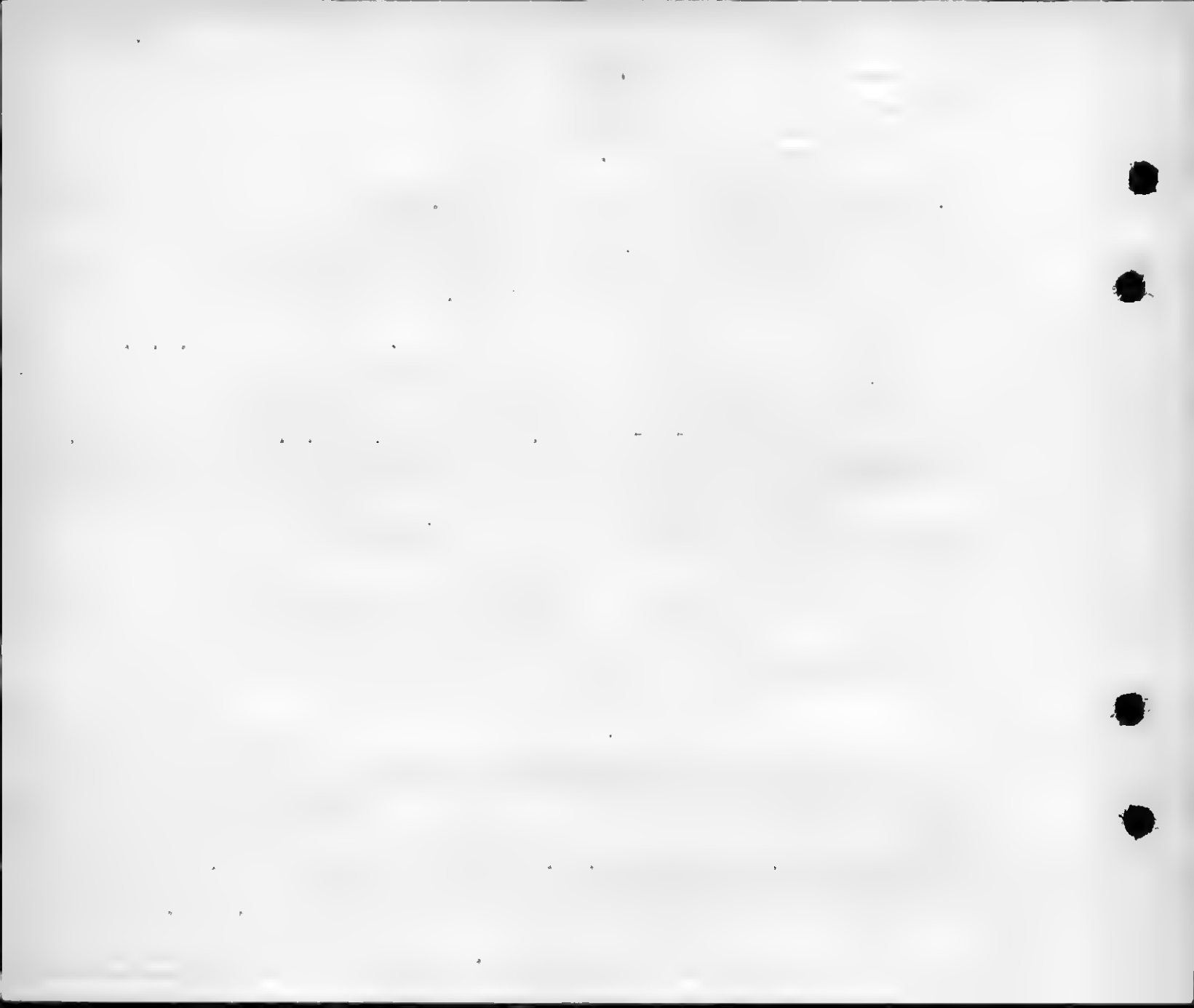
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
---	--	--

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>59</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>		

21. I certify that I attended the deceased from <u>July 12, 1958</u> to <u>June 13, 1959</u> , that I last saw the deceased alive on <u>June 12, 1959</u> , and that death occurred at <u>8:30 A.</u> M. from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>Herbert H. Leighton</u> M.D. <u>77 Oak Street, Oakland, Md.</u> DATE SIGNED <u>14 June 59</u>	
PHYSICIAN'S NAME (Type) <u>Herbert H. Leighton, M. D.</u> <u>Oakland, Maryland.</u>	

22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/15/1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Thayerville Cemetery</u>	22d. LOCATION (City, town, or county) <u>Garrett Co., Md.</u> (State) <u> </u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Leighton</u> ADDRESS <u>Oakland, Md.</u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u>JUN 16 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6808

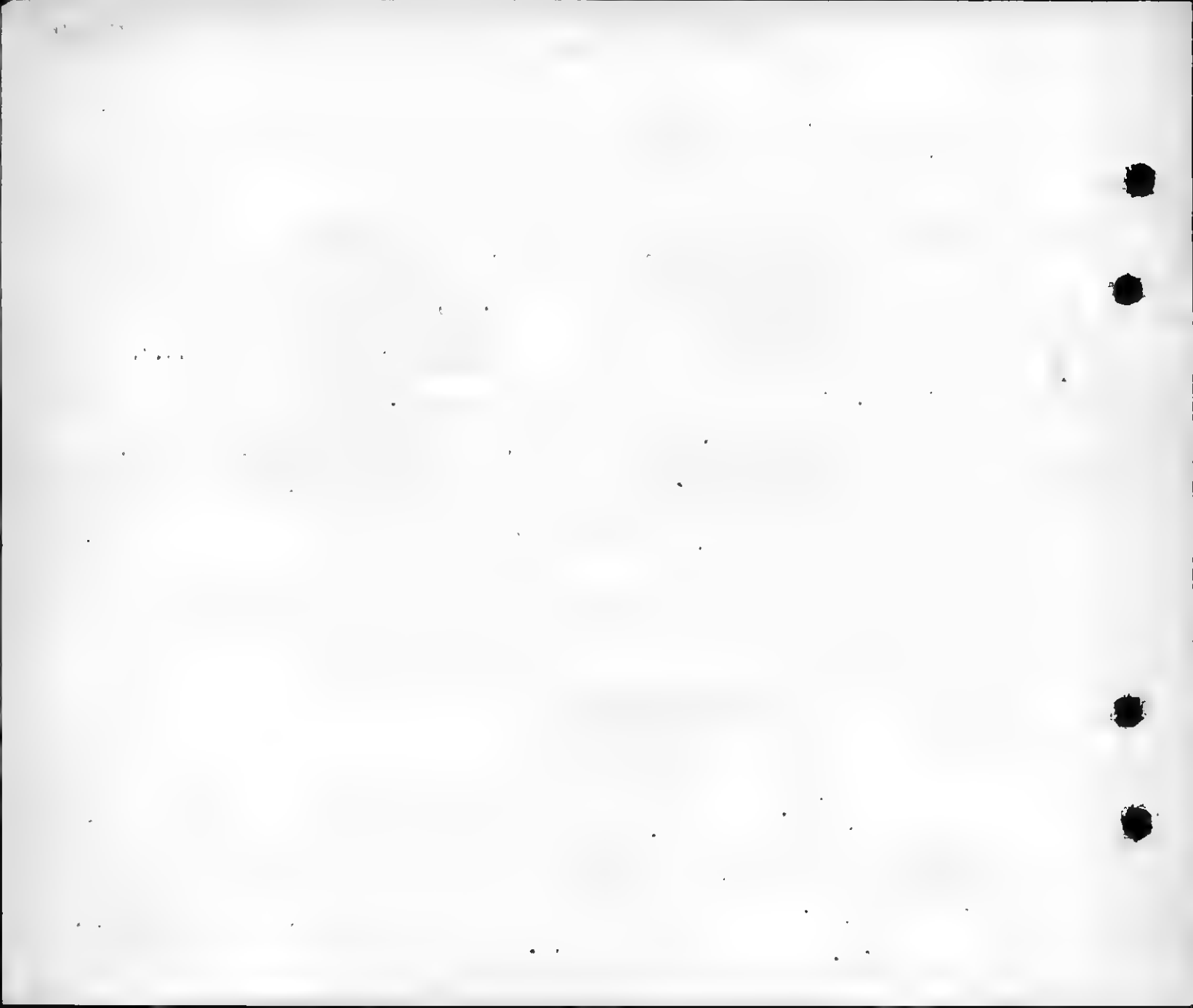
CERTIFICATE OF DEATH

06798

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Garrett</u>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bloomington</u>		c. LENGTH OF STAY IN 1b <u>49 Yrs</u>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Md</u>		b. COUNTY <u>Garrett</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bloomington</u>		d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Roy</u> Middle <u>Oecil</u> Last <u>Miller</u>				4. DATE OF DEATH Month <u>June</u> Day <u>6</u> Year <u>1959</u>											
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 10, 1910</u>		9. AGE (in years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		IF UNDER 24 HRS Hours <u> </u> Min <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>				11. BIRTHPLACE (State or foreign country) <u>Bloomington</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Oliver O. Miller</u>						14. MOTHER'S MAIDEN NAME <u>Florence R. Duckworth</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>0</u>		INFORMANT <u>Mrs. Florence Miller-Bloomington, Md.</u>				Address <u> </u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Failure</u> <u>353.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Epileptic Seizure</u> DUE TO (c) <u> </u>												INTERVAL BETWEEN ONSET AND DEATH <u>1 hr - 1 hr - 1 hr -</u> <u>Life</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u> </u>											
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June 1, 1940</u> to <u>June 6, 1959</u> that I last saw the deceased alive on <u>6/6</u> , 19 <u>59</u> , and that death occurred at <u>4:00</u> M, from the causes and on the date stated above.												ADDRESS (Street, city or town, state) <u>Piedmont W. Va.</u>			
ACTUAL SIGNATURE <u>P. E. Berry</u>				M.D. <u>Piedmont W. Va.</u>				DATE SIGNED <u> </u>							
PHYSICIAN'S NAME (Type) <u> </u>															
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/9/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Philos</u>				22d. LOCATION (City, town, or county) (State) <u>Westernport Md.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>St. Boul</u>				ADDRESS <u>Westernport Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>					

Page 4
death
within 24 hours
The law requires that the death certificate be executed within 24 hours of death.
The attending physician and the funeral director, after the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6809

CERTIFICATE OF DEATH

06799

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) VINDEX		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) VINDEX	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WEST VINDEX		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle WILLIAM Last NELSON		4. DATE OF DEATH Month JUNE Day 22 Year 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 3, 1872
9. AGE (In years, months, days, hours, minutes) 87 yrs. 1 month 19 days 1 hour 59 min		10. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) MINER	
11. KIND OF BUSINESS OR INDUSTRY COAL MINES		12. BIRTHPLACE (State or foreign country) GRANT CO., W.VA.	
13. CITIZEN OF WHAT COUNTRY? U.S.A.		14. FATHER'S NAME PHILIP NELSON	
15. MOTHER'S MAIDEN NAME NANCY		16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	
17. SOCIAL SECURITY NO. NONE		18. INFORMANT Address Mrs. Tenna Paugh, R#1, Swanton, Md.	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Corning Thrombosis DUE TO Corning Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) 54 lying cause (c) 54		INTERVAL BETWEEN ONSET AND DEATH 54	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1950 to June 22, 1957 , that I last saw the deceased alive on June 22, 1957 , and that death occurred at 4:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Ralph Calandrella		DATE SIGNED 6/23/59	
PHYSICIAN'S NAME (Type) Dr. Ralph Calandrella, M.D.		Kitzmilller, Md.	
22a. BURIAL, CREMATION, or other disposal (Specify) Burial	22b. DATE THEREOF 6/25/59	22c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery	22d. LOCATION (City, town, or county) (State) R#1, Swanton, Garrett Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE H.C. Kington		ADDRESS Oakland, Md.	
24a. REC'D BY REGISTRAR JUN 29 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After it has been signed by the attending physician and completed, it should be filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

دوره اول (۱۳۳۵) ال
(تیمور) و ۱۳۳۶

دوره دوم (۱۳۳۷) ال
دوره سوم (۱۳۳۸) ال

6810

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06800

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland. b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Swanton,				c. LENGTH OF STAY IN 1b 63 yrs.			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Swanton				d. STREET ADDRESS 1 Mile west, on farm			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1 Mile west of Swanton				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Lewis Last Otto				4. DATE OF DEATH Month June Day 17, Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 6, 1896	
9. AGE (in years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months Days 		11. IF UNDER 24 HRS. Hours Min 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter & Farmer				10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Maryland.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William H. Otto				14. MOTHER'S MAIDEN NAME Mary Elizabeth O'Brien			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 220-16-5864		17. INFORMANT Miss Nina Otto Address Swanton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Myocardial Infarction, acute DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 minutes							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocardial infarction March 1958							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James H. Feaster, Jr., M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 6/20/1959		22c. NAME OF CEMETERY OR CREMATORY North Gladd Cemetery	
22d. LOCATION (City, town, or county) near Swanton, Md.				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. Leighton</i>				ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR JUN 18 '59	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. House</i>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 is to be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6811 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06801

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Kitzmiller				c. LENGTH OF STAY IN 1b ---			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 42, 4 Mi. N. Kitzmiller				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ira Middle Everett Last Paugh				4. DATE OF DEATH Month June Day 27 , Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 15, 1930	
9. AGE (In years last birthday) 28 yrs.		IF UNDER 1 YEAR Months 28 Days 28		IF UNDER 24 HRS. Hours 28 Min. 28			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY General		11. BIRTHPLACE (State or foreign country) Maryland.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Ira Hobart Paugh				14. MOTHER'S MAIDEN NAME Ethel May Paugh			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) no		16. SOCIAL SECURITY NO. 215-26-9783		17. INFORMANT Ethel May Paugh		Address Vindex, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) FRACTURED SKULL 823 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CRUSHED CHEST DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto accident, car ran off of road and turned over killing driver.					
20c. TIME OF INJURY Month, Day, Year 10:40 p.m. 6-27 59		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) Rural Vindex, Garrett, Md. (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>James H. Feaster Jr.</i> EXAMINER'S NAME (Type) James H. Feaster Jr. M. D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED 6-27-59							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/29/1959		22c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery		22d. LOCATION (City, town, or county) near Swanton, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. C. Lighten</i> ADDRESS Oakland, Md.				24a. REC'D BY REGISTRAR DATE JUL 1 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6812

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06802

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY GRANT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BAYARD			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED Artenchie First LONG Middle PENNINGTON Last				4. DATE OF DEATH Month JUNE Day 12 Year 1959			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 1, 1884		9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SAMUEL LONG				14. MOTHER'S MAIDEN NAME Not known			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. -----		17. INFORMANT BLAKE PENNINGTON		Address BAYARD, W.VA.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion, Acute 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardio Vascular Disease DUE TO 20 years (c)						INTERVAL BETWEEN ONSET AND DEATH Minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ① Lobar Pneumonia ② Diabetes Mellitus							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 1957 to June 12, 1959 , that I last saw the deceased alive on June 12, 1959 , and that death occurred at 5:55 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Herbert H. Leighton		M.D.		ADDRESS (Street, city or town, state) 77 Oak St. Oakland, Md.		DATE SIGNED 13 Jan 59	
PHYSICIAN'S NAME (Type) HERBERT H. LEIGHTON, M.D.		77 OAK STREET		OAKLAND, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/15/1959		22c. NAME OF CEMETERY OR CREMATORY Lanesville Cemetery		22d. LOCATION (City, town, or county) (State) Tucker County, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE H. C. Leighton				ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR JUN 16 59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Thoma			

6813

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06803

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Md. b. COUNTY Allegheny			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Swanton		c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2 Mi W. Swanton				d. STREET ADDRESS 418 Hammond			
3. NAME OF DECEASED (Type or print) Marion Francis Reeves				4. DATE OF DEATH June 6 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 24, 1897		9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) District Manager		10b. KIND OF BUSINESS OR INDUSTRY O & A Gas Co.		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard Reeves				14. MOTHER'S MAIDEN NAME Mary Frye			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-05-8162		17. INFORMANT Address Mrs Marion Reeves- Westernport, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DROWNING 850 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH Imm.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Apparently fell in the water while refueling his motor. He was fishing alone at the time.					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 6/ - 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Deep Creek Lake		20f. (City or town) (County) (State) Garrett Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James H. Feaster, Jr.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 6 7-59	
EXAMINER'S NAME (Type) James H. Feaster, Jr. M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/10/59		22c. NAME OF CEMETERY OR CREMATORY Philos		22d. LOCATION (City, town, or county) (State) Westernport Md.	
23. FUNERAL DIRECTOR'S SIGNATURE E.S. Boal				ADDRESS El. Boal, Westernport, Md		24a. REC'D BY REGISTRAR DATE JUN 9 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Hume			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

6814

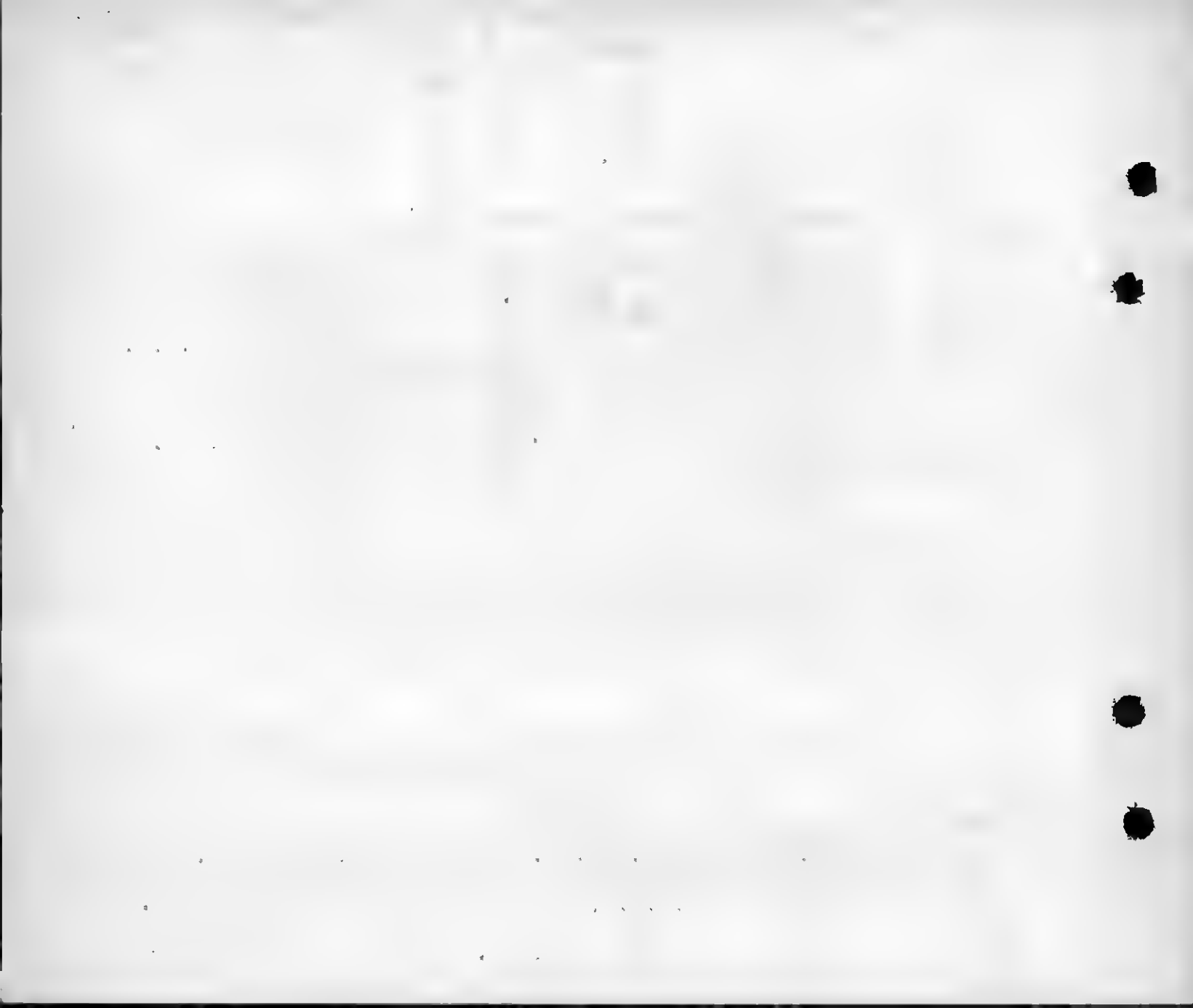
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

06804

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland,		c. LENGTH OF STAY IN 1b 3½ yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		d. STREET ADDRESS Paca Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Weeks Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Myrtle Middle Mongold Last Simmons		4. DATE OF DEATH Month June Day 23 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 1885
9. AGE (In years last birthday) 75 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse and		10b. KIND OF BUSINESS OR INDUSTRY House work	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Mongold		14. MOTHER'S MAIDEN NAME Martha Pratt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Mrs. Vincent Wigger		915 Atlantic Ave. Lavale, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MI Infarction DUE TO MI Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchitis DUE TO Unrein (c) Unrein		INTERVAL BETWEEN ONSET AND DEATH 3 weeks 7 months 6 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JAN 1 , 19 57 to JUNE 22 , 19 59 , that I last saw the deceased alive on JUNE 22 , 19 59 , and that death occurred at 8:55P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 58 2-1st. Oakland, Md. DATE SIGNED 6-25-59			
ACTUAL SIGNATURE James H. Feaster Jr.		M.D. 58 2-1st. Oakland, Md.	
PHYSICIAN'S NAME (Type) James H. Feaster Jr., M. D.		Oakland, Maryland.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/26/1959	
22c. NAME OF CEMETERY OR CREMATORY I.O.O.F. Cemetery		22d. LOCATION (City, town, or county) (State) Elk Garden, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE H.C. Leighton		ADDRESS Oakland, Md.	
24a. REC'D BY REGISTRAR DATE JUN 29 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kneale	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 48 hours after death.

6815

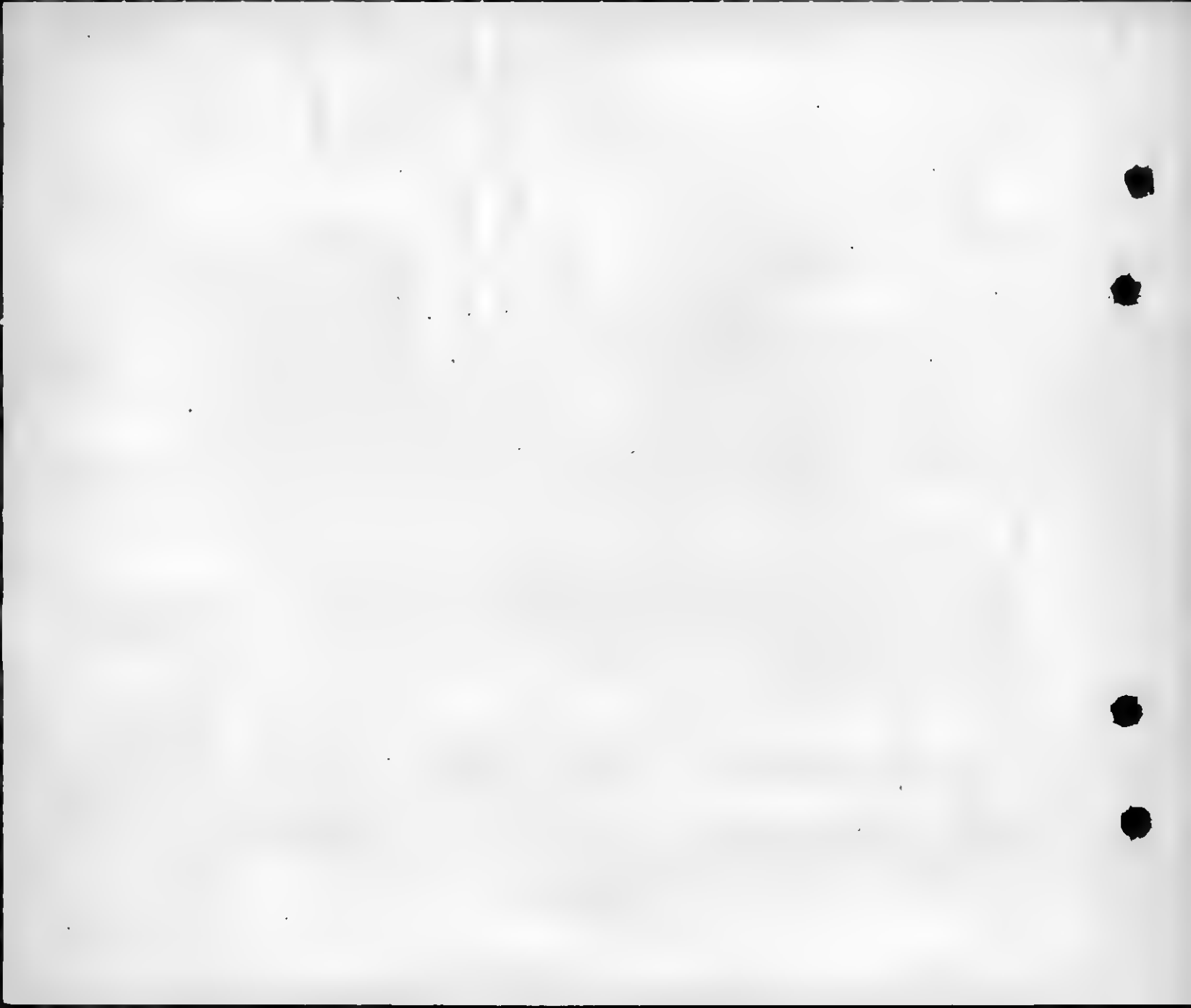
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

06805

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harvett</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>11 Heavely Terrace</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Carl</u> First <u>SPEELMAN</u> Middle <u>Speelman</u> Last		4. DATE OF DEATH Month <u>6</u> Day <u>20</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 14, 1876</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR: Months <u>6</u> Days <u>20</u> Hours <u>19</u> Min <u>5</u>	
10a. USUAL OCCUPATION (Give kind of work, done during most of working life, even if retired) <u>Retired Shipyard</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	
11. BIRTHPLACE (State or foreign country) <u>Hazen Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George Speelman</u>		14. MOTHER'S MAIDEN NAME <u>Phoenix Leanne</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or date of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Anna Molinari</u> Address <u>Cumt. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>723.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>A. ...</u> (c) <u>C. ...</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-0-59</u> , 19 <u>59</u> , to <u>6-20-59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6-27-59</u> , 19 <u>59</u> , and that death occurred at <u>11:30</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James H. Feister, Jr.</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>6-27-59</u>	
PHYSICIAN'S NAME (Type) <u>JAMES H. FEISTER, JR., M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/23/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Dunsmuir Mans. Pk.</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc.</u> ADDRESS <u>Cumt. Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 25 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinn</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

6818 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06806

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OKLAND		c. LENGTH OF STAY IN 1b 24 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		d. STREET ADDRESS 13 Decatur St.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) CUPPET NURSING HOME				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Philip Middle Timbrook Last				4. DATE OF DEATH Month 6 Day 9 Year 19 59				
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 17, 1873		9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. farmer		10b. KIND OF BUSINESS OR INDUSTRY Own farm		11. BIRTHPLACE (State or foreign country) W. Va.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Taylor Timbrook		Address Cumberland, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 442X IMMEDIATE CAUSE (a) UREMIA DUE TO CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) MALNUTRITION DUE TO (c) ARTERIOSCLEROTIC CARDIO-RENAL DISEASE								INTERVAL BETWEEN ONSET AND DEATH weeks weeks years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE James H. Feather, Jr.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
EXAMINER'S NAME (Type) JAMES H. FEATHER, JR., M. D.				DATE SIGNED 6-9-59				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 12, 1959		22c. NAME OF CEMETERY OR CREMATORY Ebenezer Cemetery		22d. LOCATION (City, town, or county) (State) Romney, W. Va.		
23. FUNERAL DIRECTOR'S SIGNATURE Byron Knight				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE JUN 11 '59		
				24b. REGISTRAR'S SIGNATURE Arthur L. Huns				

WEST VIRGINIA STATE DEPARTMENT OF HEALTH - BIRMINGHAM 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Taylor, Thomas		Male		35	
Residence		Occupation		Cause of Death	
Gumbertown, W. Va.		Unknown		Heart Disease	
Date of Death		Time of Death		Place of Death	
May 17, 1935		10:15 A.M.		Home	
Physician		Medical Examiner		Signature	
J. H. Smith		J. H. Smith		J. H. Smith	
City		County		State	
Gumbertown		Lincoln		West Virginia	
Date of Report		Time of Report		Signature	
May 18, 1935		1:30 P.M.		J. H. Smith	
City		County		State	
Gumbertown		Lincoln		West Virginia	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6817

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06807

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRET MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W. VA. b. COUNTY MONONGALIA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MORGANTOWN (RURAL)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Evans Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROSE Middle Florence Last Wisman		4. DATE OF DEATH Month JUNE Day 6 Year 1950	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 20, 1880
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Anthony Smith		14. MOTHER'S MAIDEN NAME Margaret Morgan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		17. INFORMANT Address Brooks Wisman RD Morgantown, W. Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA 442 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC CARDIO RENAL DISEASE DUE TO (c) HYPERTENSION		INTERVAL BETWEEN ONSET AND DEATH 3 weeks YEARS YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) OLD CEREBRAL VASCULAR ACCIDENT		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-3-59 , 19 59 , to 6-5-59 , 19 59 , that I last saw the deceased alive on 6-5-59 , 19 59 , and that death occurred at 8:50A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 58 2ND. ST., OAKLAND, MARYLAND DATE SIGNED 6-6-59			
ACTUAL SIGNATURE James H. Feaster, Jr. M.D.		PHYSICIAN'S NAME (Type) JAMES H. FEASTER, JR., M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/8/1959	
22c. NAME OF CEMETERY OR CREMATORY Beverly Hills Memorial Cemetery		22d. LOCATION (City, town, or county) (State) Morgantown, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Leighton - Oakland ADDRESS Oakland		24a. REC'D BY REGISTRAR JUN 8 '59 24b. REGISTRAR'S SIGNATURE Charles L. Hume	

